SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

DISABILITY REPORT
ADULT

For SSA Use Only
Do not write in this box.

Related SSN Number Holder _____

SECTION 1 — INFORMATION ABOUT THE DISABLED PERSON

A. **NAME** *(First, Middle Initial, Last)*: JOHN QUINCY DOE

B. **SOCIAL SECURITY NUMBER**: 999-00-1234

C. DAYTIME TELEPHONE NUMBER *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

410 (Area Code) 555-9999 (Number) Your Number ☑ Message Number ☐ None ☐

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help you with your claim.

NAME JANE DOE RELATIONSHIP WIFE

ADDRESS 456 HANOVER PIKE
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

Anywhere (city) USA (State) 90720 (ZIP) DAYTIME PHONE 410 (Area Code) 555-1999 (Phone Number)

E. What is your **height** without shoes? 5 ' (feet) 7 " (inches)

F. What is your **weight** without shoes? 308 (pounds)

G. Do **you** have a **medical assistance card?** (For example, Medicaid or Medi-Cal) YES ☐ NO ☒
If "YES," show the **number** here: _____

H. Can **you speak English?** YES ☒ NO ☐ If "NO," what languages can you speak? _____

If **you cannot speak English,** is there someone we may contact who speaks English and will give you messages? *(If this is the same person as in "D" above, show "SAME" here.)*

NAME _____ RELATIONSHIP _____

ADDRESS: _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ (city) _____ (State) _____ (ZIP) DAYTIME PHONE _____ (Area Code) _____ (Phone Number)

I. Can **you read English?** YES ☒ NO ☐

J. Can you **write more than your name in English?** YES ☒ NO ☐

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the **illnesses, injuries or conditions** that limit your ability to work? High blood pressure, heart problems, arthritis in my hands ands Knees, depression

How do your illnesses, injuries or conditions limit your ability to work? I am no longer able to do my past work. I can no longer stand for more than 5 minutes, and I get chest pain if I walk for more than a half block.

C. Do your illnesses, injuries or conditions cause **you pain?** YES [X] NO [ ]

D. When did your illnesses, injuries or conditions **first bother you?**

Month	Day	Year
03	04	98

E. When did **you** become **unable to work** because of your illnesses, injuries or conditions?

Month	Day	Year
05	12	98

F. Have **you ever worked?** YES [X] NO [ ] *(If "NO," go to* **Section 4.)**

G. Did you **work at any time** after the date your illnesses, injuries or conditions first bothered you? YES [X] NO [ ]

H. If "YES," did your illnesses, injuries or conditions cause you to: (Check all *that apply,)*

- [ ] **work fewer hours?** *(Explain below.)*
- [X] **change your job duties?** *(Explain below.)*
- [X] **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below.)*

I no longer use any heavy equipment. This was done by other staff workers. I was responsible for emptying trash cans and replacing the restroom supplies.

I. Are **you working now?** YES [ ] NO [X]

If "NO," when did you **stop working?**

Month	Day	Year
5	12	98

Why did **you stop working?** I was having too much pain, and it was difficult for me to walk.

SECTION 3 – INFORMATION ABOUT YOUR WORK

A. List all the **jobs** that you have had in the **last 15 years that you worked.**

JOB TITLE *(Example, Cook)*	TYPE OF BUSINESS *(Example, Restaurant)*	DATES WORKED *(month & year)* FROM	TO	HOURS PER DAY	DAYS PER WEEK	RATE OF PAY (Per hour, day week, month or year)
JANITOR	GOVT.	1/80	5/98	8	5	$ 18,523.00 /YR
						$ /
						$ /
						$ /
						$ /
						$ /
						$ /

B. Describe the **job above** that you did the **longest.** (What did you do all day in this job?)

Buffed and waxed floors, emptied trash cans and replaced restroom supplies.

C. In **this job,** did you:

Use machines, tools or equipment?	YES [X] NO [ ]
Use technical knowledge or skills?	YES [ ] NO [X]
Do any writing, complete reports, or perform any duties like this?	YES [ ] NO [X]
Did you supervise other people?	YES [X] NO [ ]
If "YES," was this your main duty?	YES [ ] NO [X]

D. In **this job,** how many total hours each day did you:

Walk?	8	Kneel? *(Bend legs to rest on knees.)*	4
Stand?	8	Crouch? *(Bend legs and back down & forward.)*	4
Sit?	6	Crawl? *(Move on hands & knees.)*	0
Climb?	0	Handle, grab or grasp big objects?	8
Stoop? *(Bend down and forward at waist.)*		Write, type or handle small objects?	1

E. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

Had to CARRY Boxes of Cleaning supplies, toilet paper and hand towels; 50-60 lbs.

F. Check **heaviest** weight lifted:

[ ] Less than 10 lbs. [ ] 10 lbs. [ ] 20 lbs. [ ] 50 lbs. [X] 100 lbs. or more [ ] Other _____

G. Check weight **frequently** lifted: (By *frequently, we mean from 1/3 to 2/3 of the workday.)*

[ ] Less than 10 lbs. [ ] 10 lbs. [ ] 25 lbs. [X] 50 lbs. or more c l Other _____

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have **you** been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? YES [X] NO [ ]

B. Have **you** been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? YES [X] NO [ ]

If you answered "NO" to both of these questions, go to Section 5.

C. List **other names** you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. **List each DOCTOR/HMO/THERAPIST.** Include **your next appointment.**

1.

NAME	DATES
DR I. Feelbetter	
STREET ADDRESS: 123 Hospital DR.	FIRST VISIT: 3/4/98
CITY: Anywhere STATE: USA ZIP: 90720	LAST SEEN: 8/28/98
PHONE: 410 (Area Code) 555-2999 (Phone Number) CHART/HMO #	NEXT APPOINTMENT: 4/16/98
REASONS FOR VISITS: treatment for heart problems, chest pain, and high blood pressure.	
TREATMENT WAS RECEIVED? medication, lab test, blood test, and exercise test	

2.

NAME	DATES
DR M. OSTEO	
STREET ADDRESS: 2468 INTERNIST Pike	FIRST VISIT: 1/12/98
CITY: Anywhere STATE: USA ZIP: 90720	LAST SEEN: 8/24/98
PHONE: 410 (Area Code) 555-3999 (Phone Number) CHART/HMO #	NEXT APPOINTMENT: 9/8/98
REASONS FOR VISITS: ARTHRITIS and DEPRESSION	
WHAT TREATMENT WAS RECEIVED? medicatim	

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST

NAME	DATES
CARDIAC REHAB. CENTER	
STREET ADDRESS: 742 HART DR	FIRST VISIT: 5/1/98
CITY: ANYWHERE STATE: USA ZIP: 90720	LAST SEEN: 7/25/98
PHONE: 410 (Area Code) 555-5999 (Phone Number) CHART/HMO #:	NEXT APPOINTMENT: N/A

REASONS FOR VISITS POST-SURGICAL REHAB.

WHAT TREATMENT WAS RECEIVED? EXERCISE PROGRAM

If you need more space, use Remarks, Section 9

E. List each HOSPITAL/CLINIC. Include **your next appointment.**

HOSPITAL/CLINIC	TYPE OF VISIT	DATES
NAME: Doctor's Hospital	☒ **INPATIENT** STAYS (*Stayed at least overnight*)	DATE IN: 3/4/98 DATE OUT: 3/18/98
STREET ADDRESS: 5432 Hope DR	☐ **OUTPATIENT** VISITS (*Sent home same day*)	DATE FIRST VISIT: DATE LAST VISIT:
CITY: Anywhere STATE: USA ZIP: 90210	☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS
PHONE: 410 (Area Code) 555-4999 (Phone Number)		

Next **appointment** N/A Your hospital/clinic **number** # 000-123-4567-89

Reasons for visits Chest pain

What **treatment** did you receive? Bypass surgery

What **doctors** do you see at this hospital/clinic on a regular basis? Dr Feelbetter

HOSPITAL/CLINIC

2.

HOSPITAL/CLINIC	TYPE OF VISIT	DATES
NAME	☐ **INPATIENT** STAYS *(Stayed at /east overnight)*	DATE IN / DATE OUT
STREET ADDRESS	☐ **OUTPATIENT VISITS** *(Sent home* **same day)**	DATE FIRST VISIT / DATE LAST VISIT
CITY STATE ZIP	☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS
PHONE Area Code Phone Number		

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9

F. Does **anyone else have medical records or information** about your illnesses, injuries, or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

YES ☐ *(If "YES," complete the information below.)* NO ☒

NAME	DATES
STREET ADDRESS	FIRST VISIT
CITY STATE ZIP	LAST SEEN
PHONE Area Code Phone Number	NEXT APPOINTMENT

CLAIM NUMBER *(If any)* _____

REASONS FOR **VISITS?** _____

If you need more space, use Remarks, Section 9

SECTION 5 – MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? YES ☐ NO ☐
If "YES," please tell us the following: *(Look at your medicine bottles, if necessary..)*

NAME OF MEDICINE	PRESCRIBED BY *(Name of Doctor)*	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE
COUMADIN	DR. FEELBETTER	CHEST PAIN	NONE
NITRO GLYCERIN	" "	" "	"
MOTRIN	DR. OSTEO	ARTHRITIS	"
PROZAC	" "	DEPRESSION	"

If you need more space, use Remarks, Section 9

SECTION 6 – TESTS

Have you had, or will you have, any **medical tests** for your illnesses, injuries or conditions?
YES ☐ NO ☐ If "YES," please tell us the following: (Give *approximate dates, if necessary.)*

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? *(Month, day, year)*	WHERE DONE? *(Name of Facility)*	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)	3/98	DR's HOSPITAL	DR. FEELBETTER
TREADMILL (EXERCISE TEST)	3/98	" "	"
CARDIAC CATHERETIZATION	3/98	" "	"
BIOPSY Name of body part _____			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)	3/98	If "	DR. FEELBETTER
BREATHING TEST			
X-RAY Name of body part KNEES	1/98	DR's OFFICE	DR. OSTEO
M RI/CT SCAN Name of body part _____			

If you have had any other tests, fist them in Remarks, Section 9.

SECTION 7 – EDUCATION/TRAINING INFORMATION

A. Circle the highest grade of **school** completed.

0 1 2 3 4 5 6 7 8 9 (10) 11 12 GED College: 1 2 3 4 or more

Approximate **date** completed: 1957

B. Did you attend **special education** classes? YES ☐ NO ☒ If "YES,"

NAME OF SCHOOL MACO COUNTY H.S.

ADDRESS 3961 AMITY RD
(Number, Street, Apt. No. (if any), P. 0. Box, or Rural Route)

ANYWHERE USA 90210
City State *ZIP*

DATES ATTENDED 1955 TO 1957

TYPE OF PROGRAM

C. Have you completed any type of **special job training, trade or vocational school?** YES ☐ NO ☒

If "YES," what type?

Approximate date completed:

SECTION 8 – VOCATIONAL REHABILITATION INFORMATION

A. Have you received services from **Vocational Rehabilitation** or any other organization to help you get back to work? YES ☐ NO ☒ If "YES,"

NAME OF

NAME OF COULSELOR

ADDRESS
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

city *State* *ZIP*

DAYTIME PHONE
Area Code *Number*

DATES SEEN TO

TYPE OF SERVICES OR TESTS PERFORMED
(IQ, vision, physicals, hearing, workshops, etc.)

B. Would you like to receive rehabilitation services that could help you get back to work? YES ☐ NO ☒

SECTION 9 – REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

SECTION 9 – REMARKS

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

Signature of **claimant** or person filing on claimant's behalf (Parent, guardian)	**Date** *(Month, day, year)*
John Quincy Doe	11/4/98

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

1. Signature of **Witness**	1. Signature of **Witness**
Address (number and street, *city,* state, and *ZIP* code)	**Address** *(number and street, city, state, and ZIP code)*